STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155355	B. WING		10/14/2011
	PROVIDER OR SUPPLIEI	D REHABILITATION	4600 W	ADDRESS, CITY, STATE, ZIP CODE V WASHINGTON AVE I BEND, IN46619	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	This visit was fo	er a Recertification and Survey. Surve		CROSS-REFERENCED TO THE APPROPRIA	on loes n by sion of ation of he nce.
	Sample: 17				
		es reflect state findings nce with 410 IAC 16.2.			
	Quality review of	completed 10/20/11			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

X8D911

Facility ID:

000246

TITLE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155355			(X2) MU A. BUII B. WING	LDING G	NSTRUCTION 00	(X3) DATE COMPL 10/14/2	ETED
NAME OF P	ROVIDER OR SUPPLIER			4600 W	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVE		
WEST BE	END NURSING ANI	D REHABILITATION		SOUTH	BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0157 SS=D	A facility must immoresident; consult wand if known, notifice representative or a when there is an aresident which respotential for requiring significant changemental, or psychological statuconditions or clinical alter treatment significant in he psychosocial statuconditions or clinical alter treatment significant in a condition or clinical treatment in a condit	nediately inform the with the resident's physician; by the resident's legal an interested family member accident involving the aults in injury and has the ring physician intervention; a in the resident's physical, social status (i.e., a alth, mental, or as in either life threatening cal complications); a need to nificantly (i.e., a need to sting form of treatment due quences, or to commence a ment); or a decision to ge the resident from the d in §483.12(a). Also promptly notify the own, the resident's legal interested family member lange in room or roommate pecified in §483.15(e)(2); or ent rights under Federal or actions as specified in					
	update the addres	ecord and periodically as and phone number of the presentative or interested	F0	157	F157 Notification of Changes		11/13/2011
	facility failed to	ew and record review, the notify the physician of lts that fell within call			It is the practice of this provider to immediately inform the resident and, if known, the residents legal representative or interested famil		
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	X8D911	Facility I	D: 000246 If continuation s	heet Pa	ge 2 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155355	B. WIN	G		10/14/2011
NAME OF F	PROVIDER OR SUPPLIER	.	-	STREET A	DDRESS, CITY, STATE, ZIP CODE	_
NAME OF I	. NO VIDEN OR SUPPLIER	·	I	4600 W	WASHINGTON AVE	
WEST B	END NURSING ANI	D REHABILITATION		SOUTH	BEND, IN46619	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	1	LSC IDENTIFYING INFORMATION)	\bot	TAG	DEFICIENCY)	DATE
	*	of 9 diabetic residents			member and physician when there	
	reviewed for dial	betic call orders in a			a significant change in the residen	t's
	sample of 17.				physical, mental or psychosocial	
					status.	
	Resident # 22, #	35, # 39			What corrective action(s) will be	
	<u> </u>	•			accomplished for those residents	
	Findings include	:			found to have been affected by the	ie
	i manigs merade.				deficient practice:	
	1. The clinical re	ecord for Resident # 22,			Resident #22 – physician has been notified of previous blood glucose	
		12/11 at 1:30 P.M.,			results and is aware of this residen	
		· · · · · · · · · · · · · · · · · · ·			current status. This resident	
	indicated diagnoses of, but not limited to:				experienced no negative outcome	as
	diabetes mellitus, hypothyroidism, and				a result of this finding.	
	peripheral vascul	iar disease.			Resident #35 – physician has been	
					notified of previous blood glucose	
	A Physician Ordo	er, dated 9/4/11,			results and is aware of this resider	
	indicated, "Acc	cu Check < (less than)			current status. This resident	
	· ·	than) 400 call MD"			experienced no negative outcome	as
	(6-2334)	····			a result of this finding.	
	Review of the O	ctober 1st through 11th,			Resident #39 – physician has been	
		•			notified of previous blood glucose	
	2011, "Capillary				results and is aware of this resider	nt's
	_	", indicated the following			current status. This resident	
	blood sugar that	tell within call			experienced no negative outcome	as
	parameters:				a result of this finding.	
					How other residents having the	
	10/11/11 1:00 P.	M Accu Check - 46.			potential to be affected by the	
					same deficient practice will be	
	Resident # 22's C	Care Plan, dated 7/6/11,			identified and what corrective action(s) will be taken:	
		cument abnormal			All residents with orders for	
					accuchecks/blood glucose	
	findings and noti	пу IVID			monitoring with specific call	
		11 1 1 1			parameters have the potential to	be
		rd lacked documentation			affected by this finding. A chart	
	of physician noti	fication.			audit has been conducted to ensu	re
					all residents with accucheck order	
	2. The clinical re	ecord for Resident # 35,			have specific call parameters and	
FORM CMS-2	2567(02-99) Previous Version	ons Obsolete Event ID:	X8D911	Facility II	D: 000246 If continuation sl	heet Page 3 of 25

i i		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CO	RRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155355	B. WIN	G		10/14/2011
NAME OF PROVI	DER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE	
					WASHINGTON AVE	
WEST BEND	NURSING AND	REHABILITATION		SOUTH	BEND, IN46619	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
rev	iewed on 10/1	3/11 at 9:45 A.M.,			that any blood sugar result noted	
ind	indicated diagnoses of, but not limited to:				outside these specified call	
dia	betes mellitus	, coronary artery disease,			parameters have been reported to)
and	l congestive h	eart failure.			the physician. Any noted discrepancies will be	
					corrected/clarified and reported	
AF	Physician Orde	er, dated 4/25/11,			promptly to the physician. The	
	•	eu Checks before meals			Nurse Management Team is	
I	· ·	ll MD if blood sugar <			responsible for completion of this	
	or > 400 "	ii ivii ii oloog sugui 、			audit.	
00 1	01 / 400				What measures will be put into	
D.	Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following blood sugar that				place or what systemic changes w	rill
					be made to ensure that the	
					deficient practice does not recur:	
					A mandatory Nursing In-service wi	
fell	within call pa	arameters:			be conducted on November 1,	
					2011. This in-service will include review of the facility policy titled,	
9/3	0/11 7:15 A.N	1 Accu Check - 54.			"Blood Glucose Monitoring". This	
					in-service will emphasize the	
Res	sident # 35's C	Care Plan, dated 5/4/11,			importance of physician notification	on
ind	icated, "Blo	od sugar testing as			and documentation of physician	
ord	ered, report al	onormalities to			notification for blood glucose resu	lts
	/sician"				outside the specified call	
					parameters. The SDC/designee wi	
The	e clinical reco	rd lacked documentation			be responsible for conducting this	
I	ohysician noti				in-service. In addition, the Nurse Management Team will begin	
011	ony sician nou	neuron.			reviewing all Blood Glucose	
2	The clinical re	ecord for Resident # 39,			Monitoring Flow Records during th	ne
		,			morning meeting to ensure	
		3/11 at 11:10 A.M.,			physician notification has occurred	1
		ses of, but not limited to:			when necessary.	
		, hypertension, and			How the corrective action(s) will be	
per	ipheral neurop	oathy.			monitored to ensure the deficient	
					practice will not recur, i.e., what	
AF	Physician Orde	er, dated 1/13/11,			quality assurance program will be	·
		vologper sliding scale:			<pre>put into place: To ensure compliance with this</pre>	
150)-200=2 units,	201-250=4 units,			To ensure compliance with this	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION 00		(X3) DATE SURVEY COMPLETED		
		155355	A. BUII B. WIN	LDING IG		10/14/2	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	R			WASHINGTON AVE		
WEST B	END NURSING AN	D REHABILITATION		SOUTH	BEND, IN46619		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	l	, 301-350=8 units,			corrective action, the DNS/design will be responsible for completion		
		s < 60 or > 400 call MD			the CQI Audit Tool titled, "Blood	101	
		iding scale coverage at			Glucose Machines and		
	bedtime - only meals"				Testing/Accuchecks". This CQI too	ol	
	Davious of the A	ugust 2011 "Canillam			will be completed daily x4 weeks,		
	Review of the August 2011, "Capillary Blood Glucose Monitoring Tool",				weekly x 3 months and monthly for six months. If threshold of 90% is		
		lowing blood sugars that			not met, an action plan will be		
	fell within call pa	•			developed. Findings will be		
	Ten within can po	arameters.			submitted to the CQI Committee	for	
	8/8/11 UR (upon rising) - Accu Check -				review and follow up.		
	59. 8/10/11 7:30 A.M Accu Check - 48.				By what date the systemic chang will be completed:	es	
					Compliance Date = 11/13/11.		
		M Accu Check - 48.			compliance bate 11/15/11.		
		on rising) - Accu Check -					
	51.	m nsmg) - Accu Check -					
	31.						
	Review of the Se	eptember 2011, "Capillary					
	Blood Glucose N	Monitoring Tool",					
	indicated the foll	lowing blood sugars that					
	fell within call pa	arameters:					
		1 Accu Check - 53.					
		M Accu Check - 453.					
	9/28/11 7:00 A.N	M Accu Check - 426.					
	Review of the O	ctober 2011, "Capillary					
		Monitoring Tool",					
		lowing blood sugars that					
	fell within call pa						
	10/5/11 11:00 A	.M Accu Check - 51.					
	Interview on 10/	13/11 at 3:15 P.M., the					

000246

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
		155355	A. BUILDING	00	10/14/2011
			B. WING	ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER			W WASHINGTON AVE	
WEST BE	END NURSING AND	O REHABILITATION		TH BEND, IN46619	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENC	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		he is now aware of the			
	issues with incor	•			
	coverage and lac	k of physician			
	notification.				
	A facility policy	titled, "Blood Glucose			
		ed 3/10, indicated, "The			
	•	notified when the			
		glucose is outside the			
	physician stated				
	physician stated	parameters			
	3.1-5(a)(2)				
F0282		ded or arranged by the			
SS=E		ovided by qualified persons n each resident's written			
	plan of care.	reach resident's written			
			F0282	F282 – Services by Qualified	11/13/2011
	Based on intervie	ew and record review, the		Persons	
	facility failed to	ensure physician orders		It is the practice of this provider	
	and plan of care	were followed related to		services provided or arranged by facility be provided by qualified	tne
	blood sugars and	administration of insulin		persons in accordance with each	
	_	9 residents reviewed		resident's written plan of care.	
	with diabetes in a	a sample of 17.		What corrective action(s) will be	
				accomplished for those residents	
	Residents # 22, #	4 35, # 39, # 46, # 51, #		found to have been affected by to deficient practice:	ne
	58			Resident #22 – physician has bee	n
				notified regarding the incorrect	
	Findings include	•		administration of sliding scale	
					<u> </u>
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: >	(8D911 Facil	ity ID: 000246 If continuation	sheet Page 6 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155355 10/14/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4600 W WASHINGTON AVE WEST BEND NURSING AND REHABILITATION SOUTH BEND, IN46619 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE coverage. Sliding scale coverage orders have been re-clarified and 1. The clinical record for Resident # 22, physician is aware of this resident's reviewed on 10/12/11 at 1:30 P.M., current status. This resident indicated diagnoses of, but not limited to: experienced no negative outcome as diabetes mellitus, hypothyroidism, and a result of this finding. peripheral vascular disease. Resident #35 - physician has been notified regarding the incorrect A Physician Order, dated 9/4/11, administration of sliding scale coverage. Sliding scale coverage indicated, "...Accu Check 1 hr (hour) after orders have been re-clarified and meals, UR (upon rising), 11 AM, 430 PM, physician is aware of this resident's PB (prior to bed)....Humalog...per sliding current status. This resident scale; 150=5 units, 151-200=7 units, experienced no negative outcome as 201-250=9 units, 251-300=11 units, a result of this finding. Resident #39 - physician has been 301-350=15 units, 351-400=20 units..." notified regarding the incorrect administration of sliding scale Review of the September 2011, "Capillary coverage. Sliding scale coverage Blood Glucose Monitoring Tool", orders have been re-clarified and indicated the following 6 incorrect sliding physician is aware of this resident's scale coverage's: current status. This resident experienced no negative outcome as a result of this finding. 9/6/11 9:00 P.M. - Accu Check - 158. Resident #46 - physician has been The clinical record indicated 5 units notified regarding the incorrect given. The next available Accu Check on administration of sliding scale 9/7/11 at 9:00 A.M. was 79. coverage. Sliding scale coverage 9/9/11 9:00 P.M. - Accu Check - 172. orders have been re-clarified and physician is aware of this resident's The clinical record indicated 5 units current status. This resident given. The next available Accu Check on experienced no negative outcome as 9/10/11 at 8:00 A.M. was 101. a result of this finding. 9/11/11 6:00 P.M. - Accu Check - 245. Resident #51 - physician has been The clinical record indicated 11 units notified regarding the incorrect administration of sliding scale given. The next available Accu Check on coverage. Sliding scale coverage 9/11/11 at 9:00 P.M. was 166. orders have been re-clarified and 9/14/11 6:00 P.M. - Accu Check - 168. physician is aware of this resident's The clinical record indicated 5 units

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA	(X2) N	MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU.	ILDING	00	COMPLETED
		155355	B. WI			10/14/2011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
					WASHINGTON AVE	
		D REHABILITATION		SOUTH	BEND, IN46619	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE
	_	available Accu Check at			current status. This resident	
	9:00 P.M. was 275.				experienced no negative outcome	as
	9/15/11 6:00 P.M	I Accu Check - 190.			a result of this finding.	
	The clinical recor	rd indicated 5 units			Resident #58 - physician has been notified regarding the incorrect	
	given. The next	available Accu Check at			administration of sliding scale	
	9:00 P.M. was 16				coverage. Sliding scale coverage	
		I Accu Check - 168.			orders have been re-clarified and	
		rd indicated 5 units			physician is aware of this resident	's
		available Accu Check on			current status. This resident	
	9/16/11 at 9:00 A				experienced no negative outcome	as
	7/10/11 at 7.00 A	1.171. was 113.			a result of this finding.	
	Domin Cit C	stale on 1 = 4 11 1 1 1 1 1			How other residents having the	
		ctober 1st through 11th,			potential to be affected by the	
	2011, "Capillary				same deficient practice will be	
	_	", indicated the following			identified and what corrective action(s) will be taken:	
	4 incorrect sliding	g scale coverage's:			All residents with orders for slidin	g
					scale insulin coverage have the	
	10/1/11 6:00 P.M	I Accu Check - 144.			potential to be affected by this	
	The clinical recor	rd indicated 5 units			finding. A facility review will be	
	given. The next	available Accu Check on			conducted on all residents with	
	10/1/11 at 9:00 P				orders for sliding scale coverage.	
		1 Accu Check - 207.			This facility review will ensure all	
		rd indicated 7 units			residents with sliding scale covera	nge
		available Accu Check on			are receiving accurate units of	
	10/6/11 at 8:00 A				coverage per physician's order. A	· I
		M.M. was 42. M Accu Check - 103.			discrepancies noted during this au will be clarified/corrected at that	
					time and promptly reported to th	
		rd indicated 4 units			physician. The Nurse Managemen	
	_	available Accu Check on			Team is responsible for completic	
	10/7/11 at 8:00 A				of this audit.	
		I Accu Check - 251			What measures will be put into	
	The clinical recor	rd lacked documentation			place or what systemic changes v	vill
	of coverage. The	e next available Accu			be made to ensure that the	
	Check at 9:00 P.M	M. was 350.			deficient practice does not recur:	
					A mandatory Nursing In-service w	
	Resident # 22's C	Care Plan, dated 7/6/11,			be held on November 1, 2011. Th	nis
FORM CMS-2	567(02-99) Previous Versio		X8D911	Facility II	ID: 000246 If continuation s	heet Page 8 of 25

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DINC	00	COMPL	ETED
		155355	A. BUII B. WIN			10/14/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t e e e e e e e e e e e e e e e e e e e			WASHINGTON AVE		
WESTRI	END NI IRSING AN	D REHABILITATION			BEND, IN46619		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	·		DATE
	indicated, "Me	dications as ordered"			in-service will include review of t	-	
					facility policy titled, "Blood Gluco		
	During interview	with RN # 2 on			Monitoring". This in-service will	also	
	10/12/11 at 2:50 P.M., he indicated the				review the importance of strict	مان.	
		ined blood sugar results			adherence to all sliding scale insu		
		wrong sliding scale			orders. During this in-service, all		
		mong briding boure			nurses will be strongly encourage to follow best practice guidelines		
	coverage.				and have another nurse "double	•	
	2 The climical m	ecord for Resident # 35,			check" and verify the physician's		
		, , , , , , , , , , , , , , , , , , ,			order against the insulin drawn u		
		13/11 at 9:45 A.M.,			and prepared prior to		
		ses of, but not limited to:			administration. The Nurse		
	diabetes mellitus	, coronary artery disease,			Management Team will begin		
	and congestive h	eart failure.			reviewing all Blood Glucose		
					Monitoring Flow Records in the		
	A Physician Ord	er, dated 4/25/11,			morning meeting to ensure corre	ect	
	1 *	cu Checks before meals			sliding scale coverage has been		
		a, 11 AM, 4 PM, PB"			administered per physician's ord	er.	
	and bedtime, or	., 11 AM, 41 M, 1 D			The SDC/designee is responsible	for	
	1.01				conducting this mandatory		
	1	ian Order, dated 5/10/11,			in-service.		
	· · · · · · · · · · · · · · · · · · ·	vologper sliding scale:			How the corrective action(s) will		
	before meals onl	y: < (less than) 150=0			monitored to ensure the deficier		
	units, 150-200=2	2 units, 201-250=4 units,			practice will not recur, i.e., what		
	251-300=6 units	, 301-350=8 units,			quality assurance program will I	oe	
	351-400=10 unit	s"			put into place: To ensure ongoing compliance w	ii+h	
					this corrective action, the	1011	
	A third Physicia	n Order, dated 5/26/11,			DNS/designee will be responsible	for	
					completion of the CQI Audit tool		
		sliding scale insulin at			titled, "Blood Glucose Machines		
	bedtime"				Testing/Acuchecks". This CQI to		
					will be completed daily x4 weeks		
	Review of the A	ugust 2011, "Capillary			weekly x3 months and monthly f		
	Blood Glucose N	Monitoring Tool",			six months. If threshold of 90% i		
	indicated the fol	lowing incorrect sliding			not met, an action plan will be		
	scale coverage's:				developed. Findings will be		
					submitted to the CQI Committee	for	
			- 1				

000246

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE : COMPL		
		155355	B. WIN			10/14/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVE		
WEST BI	END NURSING ANI	O REHABILITATION			BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	The clinical reco	f Accu Check - 154. rd indicated 2 units available Accu Check on A.M. was 161.			review and follow up. By what date the systemic change will be completed: Compliance Date = 11/13/11.	es	
	Blood Glucose M	eptember 2011, "Capillary Monitoring Tool", owing incorrect sliding					
	9/8/11 8:00 P.M Accu Check - 150. The clinical record indicated 2 units given. The next available Accu Check on 9/9/11 at 7:00 A.M. was 94 Review of the October 1st through 11th, 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following incorrect sliding scale coverage's: 10/10/11 PB - Accu Check - 201. The clinical record indicated 4 units given. The next available Accu Check on 10/11/11 UR was 102.						
		Care Plan, dated 5/4/11, dications as ordered"					
	reviewed on 10/1 indicated diagnos	ecord for Resident # 39, 13/11 at 11:10 A.M., ses of, but not limited to: , peripheral neuropathy,					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155355		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/14/2	ETED	
		100000	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	10/11/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	WASHINGTON AVE		
		O REHABILITATION			BEND, IN46619		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1.10		er, dated 2/24/11,		0			5.112
	indicated, "Accu Check four times daily, UR (upon rising), 11 AM, 4 PM, PB (prior to bed)"						
	A second Physician Order, dated 1/13/11,						
	· ·	vologper sliding scale:					
		, 201-250=4 units,					
		301-350=8 units,					
	351-400=10 units**Do not give sliding						
	scale coverage at bedtime - only meals"						
	Review of the A	ugust 2011, "Capillary					
		Monitoring Tool",					
		owing 11 incorrect					
	sliding scale cov	•					
	and	-148 - 5.					
	8/1/11 8:00 P.M.	- Accu Check - 164.					
	The clinical reco	rd indicated 2 units					
	given. The next	available Accu Check on					
	8/2/11 at 8:00 A.						
		- Accu Check - 302.					
		rd indicated 8 units					
	~	available Accu Check on					
	8/3/11 at 8:00 A.						
		- Accu Check - 410.					
		rd indicated 10 units					
	8/11/11 at 9:00 F	available Accu Check on					
		- Accu Check - 279.					
		rd indicated 4 units					
		available Accu Check					
	UR was 59.	aranaoio ricon Check					
		Л Accu Check - 255.					

Facility ID:

, ,		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155355	B. WIN			10/14/2	011
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
WEGT D	END NUIDOING AN	D DELLA DIL ITATIONI			WASHINGTON AVE		
WESTBI		D REHABILITATION		SOUTH	BEND, IN46619		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG		ord indicated 4 units		IAU			DATE
		available Accu Check at					
	1 0						
	8:00 P.M. was 206. 8/10/11 8:00 P.M Accu Check - 377.						
	The clinical record indicated 10 units						
	8/11/11 UR was	available Accu Check on					
		.M Accu Check - 183.					
		ord indicated 0 units					
	given. The next						
	3:20 P.M. was 5						
	8/15/11 8:00 P.M Accu Check - 250.						
		ord indicated 4 units					
	8/16/11 at 7:00 A	available Accu Check on					
		M Accu Check - 207.					
		ord lacked documentation					
		en. The next available :00 P.M. was 218.					
		M Accu Check - 276.					
		ord indicated 6 units					
	8/27/11 UR was	available Accu Check on					
		7 Accu Check - 345.					
		ord indicated 6 units					
		available Accu Check at					
	8:30 P.M. was 6						
	0.30 1 .WI. was 0	O					
	Review of the Sa	eptember 2011, "Capillary					
		Monitoring Tool",					
		lowing 14 incorrect					
	sliding scale cov						
	Shumg Scale COV	crage 5.					
	9/1/11 8:00 P.M	Accu Check - 196.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE COMPL		
		155355	B. WIN			10/14/2	011
NAME OF F	PROVIDER OR SUPPLIER				NDDRESS, CITY, STATE, ZIP CODE WASHINGTON AVE	•	
WEST BI	END NURSING ANI	O REHABILITATION		SOUTH	BEND, IN46619		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
1710		rd indicated 2 units		1710	<u> </u>		DATE
		available Accu Check on					
	9/2/11 at 7:20 A.						
		1 Accu Check - 205.					
		rd indicated 4 units					
	given. The next	available Accu Check on					
	9/11/11 at 7:00 A						
	9/11/11 9:00 P.M	I Accu Check - 289.					
	The clinical reco	rd indicated 6 units					
	given. The next	available Accu Check on					
	9/12/11 at 7:30 A.M. was 110.						
	9/15/11 UR - Accu Check - 346. The						
	clinical record in	dicated 10 units given.					
	The next availab	le Accu Check was 12:00					
	P.M. was 171.						
	9/17/11 7:00 A.N	1 Accu Check - 401.					
	The clinical reco	rd indicated 10 units					
	1 -	available Accu Check at					
	12:00 P.M. was 1						
		I Accu Check - 219.					
		rd lacked documentation					
		n. The next available					
	Accu Check at 9						
		M Accu Check - 453.					
		rd indicated 10 units					
	~	available Accu Check at					
	12:00 P.M. was 2						
		M Accu Check - 361.					
		rd indicated 8 units available Accu Check on					
	at 4:00 P.M. was						
		ов. Л Accu Check - 208.					
		rd indicated 2 units					
		available Accu Check at					
	given. The next	avanable Accu Clicck at					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355		LDING	nstruction 00	(X3) DATE (COMPL 10/14/2	ETED
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	-	STREET A	DDRESS, CITY, STATE, ZIP CODE		
		D REHABILITATION			WASHINGTON AVE		
				l	BEND, IN46619		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	TE	DATE
	12:00 P.M. was	<u> </u>					
		M Accu Check - 374.					
	The clinical reco	ord indicated 8 units					
	given. The next	available Accu Check on					
	at 4:00 P.M. was						
	9/25/11 8:00 P.M Accu Check - 193.						
	The clinical record indicated 2 units						
	given. The next available Accu Check on						
	9/26/11 at 7:15 A	A.M. was 229.					
	9/27/11 8:00 P.N	1 Accu Check - 203.					
	The clinical reco	ord indicated 4 units					
	given. The next	available Accu Check on					
	9/28/11 at 7:00 A						
		M Accu Check - 426.					
		ord indicated 10 units					
	~	available Accu Check at					
	12:00 P.M. was 2						
		.M Accu Check - 355.					
		ord indicated 8 units					
	_	available Accu Check at					
	4:00 P.M. was 20	66.					
	Daview of the O	atabar lat through 1141					
	2011, "Capillary	ctober 1st through 11th,					
	, ,	", indicated the following					
		ig scale coverage's:					
	J mooneet shall	is source coverage s.					
	10/1/11 PB - Acc	cu Check - 188. The					
		dicated 2 units given.					
		le Accu Check on					
	10/2/11 UR was						
		cu Check - 184. The					
	clinical record in	dicated 2 units given.					
		le Accu Check on					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 10/14/2	ETED
NAME OF F	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE		
WEST BI	END NURSING AN	D REHABILITATION			WASHINGTON AVE BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	clinical record in The next availab 10/4/11 UR was Resident # 39's of updated last on a "Administer m scale as ordered Interview on 10/ DON indicated s	cu Check - 176. The adicated 2 units given. ole Accu Check on 189. Care Plan, dated 8/16/10, 8/17/11, indicated, neds as orderedSliding					
	reviewed on 10/ indicated Reside	f Resident #46 was 13/11 at 2:00 p.m., and ent #46's diagnoses ere not limited to,					
	dated 8/26/11 in to have accuche bedtime. The or Humalog 100 ur subcutaneously scale if the bloom	11 Physician's Order Sheet dicated the resident was cks before meals and at rder indicated administer nits/milliliters according to a sliding d sugar was 201 to 250 I if 251 to 300 give 3 units					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155355		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 10/14/2011		
NAME OF F	PROVIDER OR SUPPLIEF		•		DDRESS, CITY, STATE, ZIP CODE		
WEST BI	END NURSING AN	D REHABILITATION			WASHINGTON AVE BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	dated 10/4/11 at resident's blood shad received 2 urunits.	ose Monitoring Tool 4 p.m. indicated the sugar result was 257 and nits of insulin instead of 3					
	reviewed on 10/1	Resident #51 was 13/11 at 2:45 p.m., and nt #51's diagnoses re not limited to,					
	the resident was before meals and indicated admini units/milliliters s to a sliding scale	dated 5/4/11 indicated to have accuchecks lat bedtime. The order ster Novolin R 100 subcutaneously according if the blood sugar was 6 units and 251 to 300					
	dated 9/13/11 at resident's blood swas given 6 unit units. Also, on 9 resident's blood received 6 units units.	ose Monitoring Tool 11 a.m. indicated the sugar result was 284 and s of insulin instead of 9 0/16/11 at 11 a.m. the sugar was 264 and had of insulin instead of 9					
	6. The record of	Resident #58 was					

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	LDING	ONSTRUCTION 00	(X3) DATE COMPL 10/14/2	ETED
NAME OF F	PROVIDER OR SUPPLIEI	₹		ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVE		
WEST BI	END NURSING AN	D REHABILITATION		BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	(X5) COMPLETION DATE
	indicated Reside	13/11 at 9:00 a.m., and ent #58's diagnoses are not limited to,				
	dated 6/17/11 in to have accuched bedtime. An ordinated adminimately units/milliliters sto a sliding scale	sister Novolin R 100 subcutaneously according to if the blood sugar was 8 units and 351 to 400				
	dated 9/23/11 at resident's blood	ose Monitoring Tool 8 p.m. indicated the sugar result was 325 and unit instead of 8 units.				
	with the Directo regard to the Res incorrect insulin scales. The DOI why Resident's #	8:45 a.m. an interview of Nursing (DON) in sident's #46, #51 and #58 dosages with sliding N indicated she is unsure #46, #51 and #58 had brrect dosage with the				
	3.1-35(g)(2)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155355		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 10/14/2011		
	PROVIDER OR SUPPLIER	O REHABILITATION		STREET A	ADDRESS, CITY, STATE, ZIP CODE WASHINGTON AVE BEND, IN46619		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0371 SS=F	considered satisfa local authorities; a (2) Store, prepare, under sanitary cordinary cordinary facility failed to a and serving dishes and that dishes within the deficient prayers of the same of the	distribute and serve food ditions ation and interview the ensure food preparation as were clean and sanitary are stored correctly. Actice had the potential to sidents who receive in 1 of 1 facility kitchen. The of the facility's kitchen are Dietary Manager on D.A.M., the following is made: Str. the red substance less steel stirring spoon is plates plate with a chip along atte.	F0	371	F371 – Food Procure, Store/Prepare/Serve – Sanitary It is the practice of this provider to procure food from sources approvor considered satisfactory by Federal, State or local authorities and to store, prepare, distribute a serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: All specifically identified issues noted in the kitchen have been thoroughly cleaned and/or sanitiz. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: All residents have the potential to affected by this finding. Dietary st will conduct a thorough, detailed inspection for cleanliness of the entire kitchen. This inspection wil also include cleaning and sanitizin of dishes, kitchen appliances and equipment. The DSM is responsib for all cleaning and sanitation task for the Dietary Department. The DSM will record all cleaning and sanitation tasks for the Dietary Department. A daily cleaning	nd ne ed. be taff g	11/13/2011

Facility ID:

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SUR	VEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETE	ED
		155355	B. WIN			10/14/2011	1
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			WASHINGTON AVE		
WEST BI	END NI IDSING AN	D REHABILITATION			BEND, IN46619		
					- DEND, 114-0013		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE CO	OMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	The toaster oven	a had buildup of sticky			schedule will be posted for all		
	substance in the	tray along with a buildup			kitchen cleaning tasks and duties		
	of crumbs.				What measures will be put into		
					place or what systemic changes	vill	
	The microwave	had a small amount of			be made to ensure that the		
					deficient practice does not recur:		
	_	n the inside along with a			A mandatory Dietary staff In-serv		
	sticky substance	•			will be held on November 4, 2011		
					This in-service will include review		
	The top of the co	offee maker had a dust			the facility policy related to prope	er	
	buildup on the to	op.			cleaning of kitchen appliances,	-hic	
	_	•			equipment and sprinkler heads. in-service will also review proper	nis	
	Δ moderate amo	ount of dust buildup was			cleaning/sanitizing of dishes and		
		of the sprinkler heads in			utensils as well as the procedure		
		-			when chips/nicks are noted on		
	the kitchen area.				serving dishes. The DSM/designe	e is	
		D:			responsible for conducting this	C 13	
		ne Dietary Manager on			mandatory in-service. The DSM v	/ill	
		5 A.M., she indicated the			review the Daily Cleaning Schedu		
	above plates, cuj	ps, and utensils were all			and do random inspections of all		
	clean and ready	to be used. She further			cleaning responsibilities in the		
	indicated the dis	hes chip very easily. She			kitchen including appliances,		
		at the staff members are			equipment, dishes and utensils.		
	"checked out" as				How the corrective action(s) will	be	
		reas of the kitchen prior			monitored to ensure the deficien	t	
		_			practice will not recur, i.e., what		
		their shift. She further			quality assurance program will b	e	
		nance is responsible for			put into place:		
	cleaning the spri	nkler heads and she			To ensure ongoing compliance w	ı	
	would put a wor	k order in for that.			this corrective action, a Dietary C	ı	
					tool titled, "Daily Cleaning Sched	ıle"	
	3.1-21(i)(2)				will be completed twice daily x 4		
					weeks and daily thereafter. The		
					DSM/designee is responsible for		
					compliance with this CQI tool.		
					Findings will be submitted to the	ı	
					Committee for review and follow	· ·	
					By what date the systemic chang	es	
	ı						

AND PLAN OF CORRECTION IDENTIFICAT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155355	B. WING			10/14/2	011
			B. WIIV	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			4600 W	WASHINGTON AVE		
WEST BE		REHABILITATION			BEND, IN46619		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					will be completed:		
F0508 SS=D	and other diagnos needs of its reside	rovide or obtain radiology tic services to meet the nts. The facility is e quality and timeliness of			Compliance Date = 11/13/11.		
	Based on intervie	ew and record review the	F0	508	F508 – Provide/Obtain		11/13/2011
	facility failed to	ensure an			Radiology/Diagnostic Services		
	_	m (EKG) was obtained			It is the practice of this provider to)	
	•	o was on a medication			provide quality and timely radiolog	gy	
	that required mor				and other diagnostic services to		
	•	•			meet the needs of its residents.		
	This deficiency affected 1 of 14 residents reviewed for diagnostic tests in a sample				What corrective action(s) will be		
					accomplished for those residents		
	of 17 (Resident #	⁴ 58).			found to have been affected by th	ie	
					deficient practice:		
	Finding Include:				Resident #58 – new EKG was		
	C				obtained for this resident on September 28, 2011. This resident		
	The record of Re	sident #58 was reviewed			experienced no negative outcome		
		00 a.m., and indicated			a result of this finding.	us	
		agnoses included, but			How other residents having the		
		•			potential to be affected by the		
	were not limited	to, bipolar.			same deficient practice will be		
					identified and what corrective		
	_	rder Sheet for October			action(s) will be taken:		
	2011 indicated an	n order dated 2/26/11 to			Any resident with orders for		
	obtain an EKG e	very 3 months due to the			radiological or other diagnostic		
	resident being pr	escribed the medication			services has the potential to be		
	geodon.				affected by this finding. A facility		
	geodon.				audit will be conducted. This audi	t	
	The Dedielers	anamta in diastad EV.Ca			will identify all residents with orde	ers	
		eports indicated EKGs			for radiology or other diagnostic		
		1/11 and 7/30/11. There			services and ensure that all tests a	ind	
	was no EKG resu	ılts for May 2011.			services have been obtained as		
					ordered. Any discrepancies noted		
	During an intervi	iew with the DON			will be clarified/corrected when		
	(Director of Nurs	sing) on 10/14/11 at			identified. The Nurse Managemer		
	, , , , , ,				Team is responsible for completion	n	

000246

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155355	B. WIN			10/14/2	011
		<u> </u>	b. Wilv		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	R			WASHINGTON AVE		
WEST DE	END NI IDRING AN	D REHABILITATION			BEND, IN46619		
WEST BE	IND NORSING AN	D REHABILITATION		300111	BEND, IN40019		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	11:45 a.m. she ii	ndicated the EKG should			of this audit. In addition, a new		
	had been done e	very 3 months, or, in May			vendor has been contracted to		
		unsure if the EKG was			provide radiological or other		
	completed.	ansare if the Eres was			diagnostic services effective		
	completed.				10/26/11.		
					What measures will be put into		
					place or what systemic changes w	vill	
	3.1-49(g)				be made to ensure that the		
					deficient practice does not recur:		
					A mandatory Nursing In-service is		
					scheduled for November 1, 2011.		
					This in-service will include review	of	
					the facility policy regarding		
					providing Radiology and Diagnosti		
					Services to the facility. The nurses	S	
					will be re-educated on the		
					procedure for ordering and		
					obtaining Radiology and Diagnosti		
					Services per physician's order. Th	ey	
					will also be re-educated on the		
					procedure for obtaining the result		
					of these tests and services as well	as	
					notification to the physician and		
					documentation regarding this		
					notification. The SDC/designee is		
					responsible for conducting this		
					in-service. The Nurse Managemer	nτ	
					Team will review all orders for		
					Radiology and Diagnostics Service		
					during the monthly Rewrite proce to ensure all tests and services ha		
					been obtained as ordered.	ve	
					How the corrective action(s) will I	ha	
					monitored to ensure the deficient		
					practice will not recur, i.e., what	•	
					quality assurance program will be	•	
					put into place:	-	
					To ensure ongoing compliance wit	th	
					this corrective action, the		
					and corrective action, the		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED		
THIND I LIMIT	or connection	155355	A. BUIL			10/14/20	
			B. WINC		DDRESS, CITY, STATE, ZIP CODE	_	
NAME OF F	PROVIDER OR SUPPLIER				WASHINGTON AVE		
WEST BI	END NURSING AND	O REHABILITATION			BEND, IN46619		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					DNS/designee will be responsible f completion of the CQI Audit tool	or	
					titled, "Labs/Diagnostics". This au	dit	
					tool will be completed monthly x 3		
					months and quarterly for six		
					months. If threshold of 90% s not		
					met, an action plan will be		
					developed. Findings will be		
					submitted to the CQI Committee for	or	
					review and follow up.	_	
				By what date the systemic change will be completed:	25		
					Compliance Date = 11/13/11.		
F0514 SS=D	each resident in ac professional stand complete; accurate accessible; and sy The clinical record information to iden the resident's asse and services provi preadmission scre	naintain clinical records on accordance with accepted ards and practices that are ely documented; readily estematically organized. must contain sufficient are estematically organized of essments; the plan of care ded; the results of any ening conducted by the			Compilance Date = 11/13/11.		
	State; and progres	s notes.	F05	514	F514 –		11/13/2011
	facility failed to divere complete are in regards to blood diabetic residents medical records in Resident # 35, # Findings include		F03	514	Records-Complete/Accurate cessible It is the practice of the provider to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; read accessible; and systematicall organized. What corrective action(s) will be accomplish for those residents found to have been affected by the deficient practice: Resident – clinical record has been	his lily ly ned	11/13/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

X8D911

Facility ID:

000246

If continuation sheet

Page 22 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPL	
AND PLAN	OF CORRECTION	155355	A. BUI	LDING	00	10/14/20	
		155555	B. WIN			10/14/20	J11
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
WEST		D DELLA DIL ITA TIONI			WASHINGTON AVE		
WESTB	END NURSING ANI	D REHABILITATION		SOUTH	BEND, IN46619		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	reviewed on 10/1	13/11 at 9:45 A.M.,			reviewed and the physician I		
	indicated diagno	ses of, but not limited to:			been made aware of the mis accucheck results. This resi		
	diabetes mellitus	, coronary artery disease,			experienced no negative out		
	and congestive h	eart failure.			as a result of this finding.	001110	
					Resident #39 - – clinical reco	ord	
	A Physician Ord	er, dated 4/25/11,			has been reviewed and the		
	-	cu Checks before meals			physician has been made av		
	and bedtime"	cu checks before means			of the missing accucheck res		
	and ocutinic				This resident experienced no		
	D : C.1 A	. 2011 . U.G 31			negative outcome as a resul this finding. How other resic		
		ugust 2011, "Capillary			having the potential to be	ients	
	Blood Glucose Monitoring Tool",				affected by the same defici	ent	
		owing 4 missing Accu			practice will be identified a		
	Check results:				what corrective action(s) w	ill	
					be taken: All residents with		
	8/3/11 11:00 A.N	И.			orders for accuchecks/blood		
	8/7/11 9:00 P.M.				glucose monitoring have the		
	8/23/11 9:00 P.M	1			potential to be affected by th finding. A facility audit and	is	
	8/31/11 11:00 A.				clinical record review will be		
	0/31/11 11.00 /1.	141.			conducted. This review will		
	Davious of the Co	entambar 2011 "Capillari			identify any resident with ord	ers	
		eptember 2011, "Capillary			for accuchecks/blood glucos		
		Monitoring Tool",			monitoring who have missing		
		owing 11 missing Accu			entries for accucheck results		
	Check results:				Any identified residents note have missing entries for	น เบ	
					accucheck/blood glucose res	_{sults}	
	9/4/11 11:00 A.N	И.			will be reported to the physic		
	9/10/11 11:00 A.	M.			promptly. New physician ord		
	9/10/11 9:00 P.M	1.			or clarifications will be obtain		
	9/11/11 7:00 A.N				and followed as ordered. Th		
	9/11/11 11:00 A.				Nurse Management Team is		
	9/14/11 11:00 A				responsible for completion of facility review. What measu		
					will be put into place or wh		
	9/17/11 11:00 A.				systemic changes will be n		
	9/21/11 11:00 A.				to ensure that the deficient		
	9/23/11 9:00 P.N				practice does not recur: A		
	9/25/11 9:00 P.N	1.			Nursing In-Service will be		

X8D911

NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		— COMI	(x3) DATE SURVEY COMPLETED 10/14/2011	
		4600 W	/ WASHINGTON AVE	CODE		
		ID PREFIX	(EACH CORRECTIVE ACTION SI	HOULD BE	(X5) COMPLETION	
`		TAG	CROSS-REFERENCED TO THE A	APPROPRIATE	DATE	
9/30/11 9:00 P.I. Resident # 35's indicated, "Bloordered 2. The clinical reviewed on 10/indicated diagnordiabetes melliture peripheral neuronal A Physician Oroma.	Care Plan, dated 5/4/11, cood sugar testing as record for Resident # 39, (13/11 at 11:10 A.M., coses of, but not limited to: s, hypertension, and opathy.		This in-service will incof the facility policy tir Glucose Monitoring". staff will be re-educated procedure for obtaining accucheck/blood glucoper physicians order the required correspondocumentation in the clinical record. The SDC/designee is responded to the service of the morning flow Record the morning meeting required documentation.	clude review tled, "Blood Nursing ted on the ng cose results as well as onding resident's ponsible for rvice. The Team will lood Glucose ords during to ensure all ion related to		
Blood Glucose indicated the fol Check results: 8/9/11 9:00 P.M.	Monitoring Tool", llowing 4 missing Accu		How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: To ensure compliance with this corrective action, the DNS/designee will be responsible			
Review of the S Blood Glucose I indicated the fol Check results: 9/12/11 5:00 P.I 9/25/11 9:00 P.I	eptember 2011, "Capillary Monitoring Tool", llowing 11 missing Accu		Tool titled, "Blood Glumachines and Testing/Accuchecks" tool will be completed weeks, weekly x 3 minonthly for six month threshold of 90% is naction plan will be de Findings will be subrecql Committee for refollow up. By what dasystemic changes we completed: Complia	cool titled, "Blood Glucose lachines and lesting/Accuchecks". This CQI leol will be completed daily x4 leeks, weekly x 3 months and leonthly for six months. If lareshold of 90% is not met, an lection plan will be developed. Findings will be submitted to the QI Committee for review and leolillow up. By what date the leavest leaves will be loompleted: Compliance Date:		
	PROVIDER OR SUPPLIE BEND NURSING AN SUMMARY S (EACH DEFICIENT REGULATORY OF P.M.) Resident # 35's indicated, "Bloordered 2. The clinical reviewed on 10/ indicated diagnoral diabetes mellitur peripheral neuronal periph	PROVIDER OR SUPPLIER BEND NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 9/30/11 9:00 P.M. Resident # 35's Care Plan, dated 5/4/11, indicated, "Blood sugar testing as ordered 2. The clinical record for Resident # 39, reviewed on 10/13/11 at 11:10 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and peripheral neuropathy. A Physician Order, dated 2/24/11, indicated, "Accu Check four times daily" Review of the August 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 4 missing Accu Check results: 8/9/11 9:00 P.M. 8/17/11 11:00 A.M. Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu	PROVIDER OR SUPPLIER BEND NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX Resident # 35's Care Plan, dated 5/4/11, indicated, "Blood sugar testing as ordered 2. The clinical record for Resident # 39, reviewed on 10/13/11 at 11:10 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and peripheral neuropathy. A Physician Order, dated 2/24/11, indicated, "Accu Check four times daily" Review of the August 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 4 missing Accu Check results: 8/9/11 9:00 P.M. 8/17/11 11:00 A.M. Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: 9/12/11 5:00 P.M. 9/25/11 9:00 P.M. 9/25/11 9:00 P.M. 9/30/11 9:00 P.M.	PROVIDER OR SUPPLIER BEND NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCIES GEACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Resident # 35's Care Plan, dated 5/4/11, indicated, "Blood sugar testing as ordered 2. The clinical record for Resident # 39, reviewed on 10/13/11 at 11:10 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and peripheral neuropathy. A Physician Order, dated 2/24/11, indicated, "Accu Check four times daily" Review of the August 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 4 missing Accu Check results: 8/9/11 9:00 P.M. Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: 9/12/11 5:00 P.M. 9/12/11 5:00 P.M. 9/30/11 9:00 P.M.	PROVIDER OR SUPPLIER SEND NURSING AND REHABILITATION SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 9/30/11 9:00 P.M. Resident # 35's Care Plan, dated 5/4/11, indicated, "Blood sugar testing as ordered 2. The clinical record for Resident # 39, reviewed on 10/13/11 at 11:10 A.M., indicated diagnoses of, but not limited to: diabetes mellitus, hypertension, and peripheral neuropathy. A Physician Order, dated 2/24/11, indicated, "Accu Check four times daily" Review of the August 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 4 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results: Review of the September 2011, "Capillary Blood Glucose Monitoring Tool", indicated the following 11 missing Accu Check results:	

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155355	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	î ´	E SURVEY PLETED /2011
NAME OF PROVIDER OR SUPPLIER WEST BEND NURSING AND REHABILITATION	STREET ADDRESS, CITY 4600 W WASHING' SOUTH BEND, IN4	TON AVE	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH COR	DER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	CROSS-REFE	RENCED TO THE APPROPRIATE	